

COMBAT AND OPERATIONAL STRESS CONCERNS FOR RESERVE FORCES

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USAWC STRATEGY RESEARCH PROJECT

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by

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ABSTRACT

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The Army Reserve had been a strategic reserve since its inception over 102 years ago, but recently Army Reserve and National Guard soldiers have been required to deploy on a rotational basis similar to their active duty counterparts. As recently as February 1991 during Operation Desert Storm under the previous strategic formation and a traditional battle field, the strategic reserves would primarily execute a rear echelon support role. In the current COIN operations in Afghanistan and Iraq, all soldiers are exposed and susceptible to direct and indirect fire even if their mission is Combat Support (CS) or Combat Service Support (CSS). This increased exposure has resulted in an escalation of reservists' risk for lingering combat stress symptoms, Post Traumatic Stress Disorder (PTSD), Minor Traumatic Brain Injury (MTBI) and suicide. Combat stress is one area that can either be exacerbated or ameliorated depending on a soldier's training, support system, and personal situation. Evidence shows differences in the lingering effects of combat stress and behavioral health in service members serving in the reserve component and the active component upon return home.

COMBAT AND OPERATIONAL STRESS CONCERNS FOR RESERVE FORCES

Reserve forces today are deployed and involved in military operations that expose them to direct and indirect fire resulting in increased rates of lingering combat stress symptoms, Post Traumatic Stress Disorder (PTSD), Minor Traumatic Brain Injury (MTBI) and suicide. There is credible evidence showing differences in lingering effects of combat stress and behavioral health concerns in service members serving in the reserve component vice those serving in the active component upon return home from deployment.¹

Role of the Operational Reserves

The Army Reserve has been a strategic reserve since its inception over 102 years ago and was designed and structured as a strategic force meant to be used as a last resort in the event of a major war.² Following the terrorist attacks on Sept 11th 2001 and the United States' involvement in the wars in Afghanistan and Iraq, the reserves transitioned to an operational force. Reservists from across the nation have since been deployed into harm's way alongside their active duty counterparts more frequently than had been anticipated. In many cases, reservists have deployed multiple times which shatters the paradigm of a force of last resort.

The reserve force contains primarily Combat Support (CS) and Combat Service Support (CSS) units and Military Occupational Skills (MOS) designed to support combat units which are mostly, but not explicitly, in the active component. Nonetheless, in today's Counter Insurgency (COIN) environment in Iraq and Afghanistan, all soldiers and units regardless of their MOS or function, are exposed and susceptible to the dangers of combat via direct fires from small arms, Rocket Propelled Grenades (RPG),

and indirect fires such as mortars, rockets and Improvised Explosive Devices (IEDs). In other words, despite maintaining a similar CS and CSS function, the reserve forces are now confronted with the same dangers as active duty soldiers while they are deployed, especially in today's COIN environment.

The impact of today's COIN environment on U.S. Soldiers is increased combat stress and lingering combat stress symptoms after returning home to civilian life. Since the drawdown of Iraq has already begun and the drawdown for Afghanistan is scheduled to begin in 2011, one could surmise that the operational reserve would be converted back to a strategic reserve, thus ending the ARFORGEN (Army Force Generation) cycle of deployments. However, as stated by Vice President Joe Biden in February 2010, "This ain't your father's National Guard".³ The 2010 U.S. Quadrennial Defense Review (QDR) stated: "Prevailing in today's wars requires a reserve component that can serve in an operational capacity – available, trained, and equipped for predictable routine deployment. Preventing and deterring conflict will likely necessitate the continued use of some elements of the reserve component – especially those with high-demand skill sets – in an operational capacity well into the future."⁴ These statements clearly imply that there will be a continued need and requirement to call on our reserve forces in a cyclical manner. This continued cyclical requirement will deter the conversion of the reserve force back to the "one weekend a month and two weeks in the summer" force that is merely preparing for the next major war.

When the use of the National Guard and the Army Reserve forces in Afghanistan and Iraq peaked in 2005, Congress created the Commission on the National Guard and Reserves to evaluate immediate wartime needs as well as enduring U.S. national

security interests. The Commission reported in January 2008 six major conclusions and 95 recommendations, concluding that the U.S. government had “no reasonable alternative” but to rely increasingly on National Guard and Army Reserves as an operational force that could participate routinely in ongoing military missions at home and abroad.⁵

The integration of reserve and active duty forces today is commonly known as the “Total Force” which was a concept that was first introduced in 1973 as a Department of Defense Policy. This is also known as the Abrams doctrine which was developed on the premise that the Army should not go to war without its reserve forces as we did in Vietnam because this severs as the connection and support between the American public and the military.⁶ It has also been suggested that this concept was developed as a checks and balance system to tie the President’s hands with the idea that he would be less likely to mobilize forces since it would include the reserve component.⁷ The implementation of the Total Force policy gained significant momentum under Secretary of Defense William S. Cohen when he submitted the concept in an annual report to the President and the Congress in 1998. Secretary of Defense Cohen concluded that the Total Force increasingly will depend on the reserve components to serve not only in their traditional wartime role, but also to provide a rotational base to ease operating and personnel tempo for a busy active component.⁸

Considering the reality that more than 30,000 reserve component soldiers deploy in harm’s way annually,⁹ the issue of combat stress and its lingering effects will not dissipate in the short term. One must also consider that if those 30,000 soldiers were to remain in CONUS (Continental United States) and not deploy in the ARFORGEN cycle,

the Army force package would have to be smaller¹⁰ or the reserve forces would have to be replaced by active component soldiers who are already stretched thin due to multiple deployments and are also dealing with increased combat stress. With the increased exposure to combat operations and associated combat stress, it is important to understand what combat stress is, what causes it, and how to deal with it.

Combat Stress – What is it?

To understand what combat stress is, it is helpful to first understand how the body reacts to external stressors. Physiological stress is defined as a specific response by the body to a stimulus, such as fear or pain, which disturbs or interferes with the normal physiological equilibrium of an organism.¹¹ “Stress is the body’s and mind’s process for dealing with uncertain change and danger”.¹² Combat stress refers to the adverse reactions personnel may experience when exposed to combat-like situations. Other names that have been used in the past to describe this reaction include shellshock, soldier’s heart, battle fatigue and battle exhaustion.¹³ In simple terms, it is the body’s response to uncertain change and danger, of which both are prevalent in combat situations. When the body is constantly and continually exposed to this environment for prolonged periods of time, the body begins to condition or train itself to protect against this stress.

Who is Susceptible to Combat Stress?

All soldiers or personnel who have been exposed to combat or combat-like situations will experience some level of combat stress.¹⁴ Combat and operational stress behavior is the term that is used to describe the full spectrum of stressors that soldiers are exposed to throughout their military experiences.¹⁵ Combat and operational stress is a reality across all military missions. The Mental Health Advisory Team (MHAT) report

VI, May of 2009, identified three key risk areas that contribute to combat stress: combat experiences or stressors, deployment concerns and the number and frequency of deployments, also known as OPTEMPO.¹⁶

Army Field Manual 6-22.5 groups these three risk areas into two specific components: combat stress and operational stress and further labels them as combat and operational stress reactions (COSR).¹⁷ Combat stressors include singular incidents that have the potential to significantly impact the unit or soldiers experiencing them. These stressors may come from a range of possible sources while performing military missions. Combat stressors include: personal injury, killing combatants, witnessing the death of an individual, the death of another unit member, injury resulting in the loss of limb.¹⁸ Operational stressors on the other hand, cover a wide range of experiences such as deployment concerns, OPTEMPO and prolonged exposure to extreme geographical environments. Examples of deployment stressors include reduced quality of life (sleep deprivation, physical discomfort) and prolonged separation from significant support systems such as family separation. OPTEMPO stressors include exposure to significant injuries or witnessing the death of several unit members over the course of many combat missions.¹⁹ Geographical stressors are the result of prolonged exposure to extreme conditions which include environments such as intense desert heat or arctic cold. An additional significant operational stressor for reserve component soldiers is the status of their civilian employment upon release from active duty (REFRAD) and return home to civilian life.

COSR represents the broad group of physical, mental and emotional signs that result from combat and operational stress exposure which is considered a subclinical

diagnosis with a high recovery rate if provided appropriate attention and time.²⁰

Traumatic Brain Injury (MTBI) is defined as a traumatically induced physiological disruption of brain function, as manifested by at least one of several conditions.²¹ The conditions include a loss of consciousness, any loss of memory for events immediately before or after the accident, any alteration in mental state at the time of the accident or focal neurological deficit(s) that may or may not be transient.²² Post Traumatic Stress Disorder (PTSD) is an anxiety disorder associated with a serious traumatic event or events.²³ According to the American Psychiatric Association, specific criteria are required to properly diagnose PTSD:²⁴ The individual must experience an event involving actual or threatened death and serious injury to self or others.²⁵ The traumatic event is persistently re-experienced with intrusive recollections of the event and the individual will persistently avoid stimuli associated with the trauma causing numbing of general responsiveness.²⁶ There is evidence of persistent symptoms of increased arousal as indicated by difficulty falling or staying asleep and irritability or outbursts of anger.²⁷ The duration of these disturbances is greater than one month and lastly the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.²⁸

Nearly one-third of troops returning from military service in Iraq and Afghanistan have experienced a MTBI or meet criteria for major depression or PTSD.²⁹ Current research shows soldiers continue to struggle with negative symptoms long after redeployment. Soldiers do not reset quickly after coming home and up to 17 percent of returned veterans may continue to struggle with negative effects even 12 months after coming home.³⁰ A study conducted by Walter Reed Army Institute of Research in

February 2005 revealed more than 15 percent of all service members returning from Iraq and 11 percent of service members returning from Afghanistan met the screening criteria for major depression, generalized anxiety, or PTSD.³¹

History of Treating Combat Stress

Combat stress control medical doctrine for preventing and treating stress casualties was learned by the United States Army from its allies during WORLD WAR I from the French and British. The French and British learned that if stress casualties were evacuated far to the rear, many became permanently incapacitated and never returned to duty. They learned that by treating stress casualties quickly and in close proximity to their units, most recovered and returned to duty.³² Based on what was learned from the French and British, The US Army Surgeon General developed a three echelon system for prevention, triage, treatment and return to duty of stress casualties.

The first echelon consisted of a trained psychiatrist at the division level to advise command leadership in the prevention of stress casualties and to screen out the unsuitable and overstressed soldiers to ensure they were rested and later returned to duty. Under good conditions, 70 percent of stress casualties treated at the first echelon were returned to duty within the division.³³ The second echelon located behind the division area, employed a specialized neurological hospital with 150 beds whose sole function was to provide additional brief rest and rehabilitation to those cases that the division psychiatrist was unable to return to duty. Approximately 55 percent of these cases were returned to duty within two weeks.³⁴ The third echelon was a specialized base hospital located even further in the rear which provided several weeks of additional treatment for soldiers who failed to improve in the neurological hospital

(second echelon). This third echelon proved successful in returning many of those cases to useful duty.³⁵

Upon entering WORLD WAR II, the military had to learn the same painful lessons all over again after several disastrous experiences when large numbers of psychiatric casualties were over evacuated from early battles.³⁶ Following WORLD WAR II, the lessons learned were embodied in a table of organization and equipment (TOE) in the form of mobile psychiatric detachments, or “KO” teams. These teams functioned very effectively in Korea.³⁷

There have been high rates of COSR from soldiers in all wars over the past 100 years. When recent operations such as Operation Desert Storm in 1991, the Balkans operations in 2001, Operation Iraqi Freedom in 2003 and Operation Enduring Freedom in Afghanistan are compared to World War I or World War II, we notice different types of conflicts. The levels of intensity in which those conflicts were waged are essentially the same; however, the lethality of the modern conflicts is potentially greater and the way that conflicts are waged in the COIN environment is more asymmetrical resulting in increased exposure to traumatic events.³⁸

The more traumatic events people encounter, the more likely they are to develop PTSD. However, PTSD is not only combat related and the prevalence of PTSD in the United States is 4 to 8 percent.³⁹ Although PTSD was not defined as a condition until 1980, there is sufficient information to estimate the relative impact on veterans’ mental health from the Vietnam War, the 1991 Gulf War and the Iraq War. Similarly in war veterans, the more intense and prolonged the combat exposure, the more likely they are to develop PTSD. Research suggests that 18 to 30 percent of Vietnam veterans, 10

to 20 percent of Iraq War veterans, and 5 to 15 percent of Gulf War veterans have experienced PTSD. This pattern is consistent with what we know about the duration and intensity of combat in these three conflicts.⁴⁰

Historically within US military Operations combat stress has accounted for up to half of all battlefield casualties, depending upon the difficulty of the conditions.⁴¹ Since introducing Combat and Operational Stress Controls (COSC) as one of the ten Army Medical Department (AMEDD) functions required to support full spectrum operations, losses due to COSR has been reduced resulting in over 95 percent these casualties returning to duty. Combat and operational stress control is a tactical consideration that must not be overlooked or minimized.⁴²

How to Minimize the Effects of Combat Stress

To mitigate the effects of COSR, we can learn from history. As early as World War II there was evidence that tough training and esprit de corps prevented many battle fatigue casualties. Elite units such as ranger and airborne units had less than one battle fatigue casualty for every ten wounded in action.⁴³ Consequently, unit cohesion and morale is the best predictor of combat resiliency within a unit or organization. Units with high cohesion tend to experience a lower rate of COSR than units with low cohesion and morale.⁴⁴ High unit cohesion and morale strengthen adaptive stress reactions in soldiers and organizations.⁴⁵ The foundation of any stress-reduction program is predicated upon trust and confidence in a soldier's leaders, training, unit, and equipment.⁴⁶

MHAT VI clearly demonstrates that leadership, specifically officer leadership, has a positive impact on reducing combat stress.⁴⁷ A unit builds confidence, esprit de corps, integrity and cohesion when leaders know their jobs.⁴⁸ In focus groups, when junior

enlisted soldiers and NCOs constantly reported garrison standards were being inconsistently implemented by senior ranking leadership, the consequences were that these inconsistencies became major contributors to the soldiers deployment stress. In contrast, positive leadership was praised by soldiers and NCOs resulting in increased unit cohesion and esprit de corps.⁴⁹ The fact that a leader is recognized by his subordinate soldiers as effective will inspire confidence in them and give them one less thing to worry about in a potentially stressful situation.⁵⁰ MHAT VI identified resilient platoons as those that had relatively low reports of behavioral health problems. Several variables were explored —unit cohesion, perception of readiness, NCO leadership and officer leadership. In this sample, the perception of officer leadership was most strongly associated with resilient platoons. Other studies have also identified the importance of NCO leadership.⁵¹

Combat stress is often measured in terms of PTSD symptoms. The Medical Monthly Service report Vol 17.No.09 Sept 2010, examined PTSD rates in both active component (AC) and reserve component (RC) soldiers along three phases; Pre-deployment, Post-deployment and reassessment within six months of the post-deployment assessment.⁵² These soldiers displayed two or more PTSD symptoms⁵³. Active and reserve soldiers were both zero percent for pre-deployment and 8.6 percent for post-deployment. Surprisingly, the reassessment data shows that 18.9 percent of reserve soldiers reported two or more PTSD symptoms compared to only 11.9 percent of active duty soldiers. In other words, while reservists and active component soldiers reported similar rates of combat stress going into combat, reservists actually reported more residual combat stress than their active component counterparts after redeploying.

However this is not new information and could have been addressed several years ago. The data from as far back as 2007 has shown that COSR upon return from combat and extended operations is similar in both the active and reserve components. For example, active and reserve soldiers returning from Iraq completed the same assessment process: the Post-Deployment Health Assessment (PDHA) and a Post-Deployment Health Re-Assessment (PDHRA) with a median of six months between the two assessments.⁵⁴ These soldiers reported more mental health concerns and were referred at significantly higher rates from the PDHRA than from the PDHA. Based on the combined screening, clinicians identified 20.3 percent of active and 42.4 percent of reserve component soldiers as requiring mental health treatment. Concerns about interpersonal conflict increased 4-fold.⁵⁵ Reserve component soldiers who had returned to civilian status were referred at higher rates on the PDHRA, which reflect their concerns about their ongoing health coverage. In the context of an overburdened system of care, the effectiveness of population mental health screening was difficult to ascertain.⁵⁶

These findings are consistent with previous research suggesting that adverse psychological health issues like mild functional impairment are detectable and may resolve to prevent further degradation of mental health when reserve soldiers receive the mandatory PDHRA screening within the required 3-6 months post redeployment.⁵⁷ Overall, the above findings show higher health referral rates for post deployed reserve soldiers who had returned to civilian status compared to their post deployed active duty counterparts.⁵⁸ This evidence suggests that it must be the culture and resource

availability upon return to civilian status that explains the disparity between the reserves and the active component.

The Impact of Combat Stress

In a September 8, 2010 speech to Army leaders about suicide prevention during an Army leader's forum at the Pentagon, General Peter W. Chiarelli, the Vice Chief of Staff of the Army, stated that "We're seeing a really disturbing increase in reserve-component suicides, I don't totally understand it, but we're working hard to try and get at it." ⁵⁹ In a commitment to address the problem of suicides in returning soldiers from the war, the Army instituted the Army Suicide Prevention Task Force, chaired by General Chiarelli. These efforts culminated in the release of the 2010 Health Promotion, Risk Reduction, and Suicide Prevention report (HP/RR/SP Report 2010) which was a 15-month study attempting to understand the increasing rate of suicides among troops. According to this study, more soldiers died in fiscal year 2009 as a result of high-risk behavior than in combat.⁶⁰

In the active component, the focus and efforts by senior leadership is finally rendering positive results. In 2010, the active component saw a decrease in suicides while the reserve component suicide rates continued to rise. However, according to Mr. Jose Mojica, Army Reserve G-1, Suicide Prevention Program Manager, in 2010 there were 49 suicides in the Army Reserve (does not include National Guard) while in 2009 and 2008 there were 35 and 27 respectfully.⁶¹

The total number of suspected suicides across the Army in fiscal year 2009 was 239 with 1,713 known attempts. When the HP/RR/SP Report 2010 was released in August of 2010, the number of potential suicides in 2010 stood at 169 -- nine less active-duty deaths than during the same period in 2009. Also, for the second year, the

Army suicide rate has surpassed the national average with about 22 per 100,000 versus 19 per 100,000 across America.⁶² General Chiarelli also said that "Suicide prevention is much more than thwarting that last final act of desperation. It is increasing awareness and education in order to preclude members of the Army family from ever getting to the point where suicide might be considered an alternative to asking for help."⁶³ It is critical to understand that combat stress can be a key factor contributing to the increased suicides in the Army Reserve.

Differences in Culture between the Active and Reserve Component

The Total Army is engaged in a suicide-prevention campaign called "Shoulder to Shoulder: I will never quit on life." All soldiers have an annual requirement to complete suicide prevention training which includes a 15-minute training video entitled "Shoulder to Shoulder".⁶⁴ The concept presented in the video is that soldiers require training and education to recognize warning signs for behavioral health issues and suicide risk factors. The issue is that due to cultural difference in the reserve component and active component, this program and its recommendations will be difficult for reservists. For example, on the training video Specialist Sanders states that the "immediate peer to your left and to your right that you talk to everyday – they are the guys that really need to watch (these peers are also known as Battle Buddies). They are the ones that will make a difference." Sanders was referring to the circumstances after his return home. This is when things became difficult for him and he began to contemplate suicide. When reserve soldiers return home, their lives are again disrupted because they are no longer surrounded by comrades on a daily basis who share similar deployment experiences.⁶⁵

The soldier's support systems which the active component and reserve component have upon return home seem to be the distinguishing difference between these two components. The reserve support system consists of employers, co-workers, communities, local and state leaders. The continued cyclical use of the reserve component forces will require a coordinated strategic communication plan to educate and inform the reserve support system of future requirements for these citizen soldiers.⁶⁶ A reservist suffering from COSR could suffer consequences at his or her civilian employment such as supervisors, co-workers and subordinates talking behind the individuals back about behavioral changes since returning from deployment. An employer may tolerate such behavioral changes for a short time but such behavior could result in job termination which will compound the stress.

Meanwhile a service member on active duty suffering from COSR at work will most likely have a battle buddy or someone who has been deployed and is educated on COSR and suicide prevention. At a minimum, a fellow soldier or supervisor will speak to the soldier about his or her behavior or may even immediately escort the soldier to the on post clinic for behavioral health assistance. This active component support system is in place and is immediately available. Although the reserve component has access and availability to 1-800 numbers and web sites for assistance, this type of support system doesn't compare to the active component. In addition to the support system, the active component also returns from deployment to fixed installations, with an entire infrastructure of support including medical, substance abuse, family programs, employment, housing etc. Once REFRADed, the reserve component service members must find treatment at the VA, Military One Source, TRICARE (6 months transitional

benefits), private insurance, community clinics etc. Although much thought and effort have gone into these response, prevention and treatment programs to support our reservists, they cannot be compared to or compete with the overall visibility, availability and convenience of the active component support programs and infrastructure.

Although the downward trend of suicides in the active component can rightfully be seen as successful, there is still work to be done to achieve the same results for the reserve component. As established above, combat stress exists during deployment for both the active and the reserve soldiers. Therefore, one can deduce that it is upon return home that disparities between the components exist.

The disparity between the rising suicide trends in the RC and the declining suicide trends in the AC has gotten the attention of leaders at the highest level. During a Video Teleconference with the Army War College in Nov 2010, a senior military leader acknowledged that the reserve component should stay at the Demobilization (DEMOB) station longer than four days. He personally had attempted to extend a reserve component unit recently redeployed from Iraq and was unsuccessful.

The military, like many organizations has been guilty of repeating history. That is a nice way of saying that we make the same mistakes over and over again. During World War II, soldiers were transported home on ships. Those journeys lasted approximately two weeks in which soldiers had time to decompress with their buddies before arriving home.⁶⁷ During the Vietnam War, this lesson was ignored and reversed. "Like most veterans, they repeated the now-familiar litany: no decompression, Vietnam on Monday Roxbury on Wednesday"⁶⁸ In spite of an abundance of data showing large quantities of PTSD cases from the Vietnam era, the Army "improved" the DEMOB

process over the last eight years, reducing the number of days at DEMOB in an effort to get the reserve soldiers off of active duty and back to their families and jobs as quickly as possible. This has been identified as a concern as it relates to combat stress and PTSD. A tiger team was assembled to assess the DEMOB process for the reserve component. The team was directed "... to evaluate the demobilization process at all of their demobilization sites to ensure reserve component units and soldiers are being processed in accordance with (IAW) all applicable regulations and policies, with emphasis on the medical screening and out-processing procedures." ⁶⁹ The results from the Demobilization Assessment Tiger Team (DAT2) were released in Sept 2010.

DAT2 concluded that demobilization tasks are generally completed successfully; however, standardization and efficiencies to the process can be achieved.⁷⁰ General observations are that 90 percent of all soldiers demobilize within five days. Eight percent of all soldiers require extra days for medical appointments and UCMJ actions at DEMOB station (DMS) and then return to home station (HS) for REFRAD and are still assigned to demobilizing Title 10 units.⁷¹ Two percent of all Soldiers require long-term hold over at the DMS for medium term medical issues without assignment to warrior transition units (WTU), awaiting assignment to WTU or UCMJ actions.⁷²

There were multiple medical issues identified by the DAT2 with several having a direct impact on behavioral health. The most prominent issues that could have a direct impact on combat stress and COSR were lack of early risk identification and transitional documentation, stigma preventing disclosure of behavioral health problems and concerns, current DEMOB requirements exceed resources, staff and facility capabilities, insufficient oversight in execution of the medical screening / out-processing

requirements, lack of RC continuity of care, and the TRICARE network is cumbersome, complex and impacts the continuity of care for RC soldiers.⁷³

There were also several non-medical issues identified by the DAT2. Three of those recommendations, according to the research, will have a direct impact on behavioral health. The most prominent recommendation was increasing the number of days at DMS from eight to seventeen. They also recommended changing the policy for attending IDT (Individual Duty / Training) or weekend battle assemblies.⁷⁴ The current policy is that soldiers do not have to attend IDT for 90 days after return to HS. The recommendation is that reservists should be required to attend Battle Assemblies at 30, 60, and 90 days IAW the Yellow Ribbon Program.⁷⁵ This aids reintegration and behavioral health. DAT2 also recommended a change for DEMOB and MOB stations allowing the units to finalize the locations at the Joint Assessment (JA) led by 1st Army. This will allow the unit leadership to schedule MOB and DEMOB at the MOB station closest to the unit resulting in easing the strain placed on families who want to visit their soldiers at MOB station prior to deploying and upon return home from deployment.

Army Reserve Policy and Plan

In an effort to address the increasing suicide rates in the reserve forces along with the high rate of PTSD in returning soldiers, the U. S. Army Reserve Command (USARC) has adopted a four-pillar plan. This four-pillar plan is known as the Army Reserve Suicide Prevention Program (ARSPP) and provides guidance and measures to prevent, intervene and safeguard against suicide. The four-pillars include: educating the entire force, reducing stigma, providing resources and involving families.⁷⁶

Of these four-pillars, the most critical component is “educating the entire force” which targets the prevention of suicide and aids in the recognition of PTSD symptoms.

Proper education has a positive affect on how our soldiers deal with normal life stressors and is a step in the right direction. However, it does not go far enough in dealing with the specific problem of lingering combat stress. The policy addresses a broad base of stressors and high risk behaviors but does not specifically address conditions related to combat stress such as a soldier's return from deployment and integration back into civilian life. Additionally, the current program cannot provide provisions to educate extended family, friends, co-workers and employers which highlight the cultural gap between the reserves and the active component.

The ARSPP directs commanders at all levels to “establish task forces, committees, and risk reduction teams to facilitate local health promotion initiatives to reduce high-risk behaviors and build resiliency.”⁷⁷ On the surface, this appears to be a positive step and may work well for a large percentage of the reserve population. However, this may be impractical for a significant portion of reserve units. While the soldier's creed says “I will never leave a fallen comrade,” there are reserve units such as a fire fighting detachment in Eldorado Kansas that are virtually on their own. This fire fighting detachment is a small group with a low density MOS with members traveling up to six hours to attend Battle Assemblies. The battle buddy system and task force concept are not practical. There are many other reserve component units and soldiers that are in a similar situation.

Conclusion

As the U.S. military presence in Afghanistan and Iraq are expected to continue through 2014, U.S. forces will still be engaged in combat and associated deployments resulting in continued combat stress potentially developing into PTSD. These two theaters of operation expose all soldiers to direct and indirect fire, including the

operational reserves even though their missions are primarily CS and CSS. This continued exposure will result in a continuation of reservists suffering from combat stress, PTSD, MTBI and suicide.

As the evidence shows in the PDHRA results, there are measurable differences between service members in the reserve component and the active component. Those differences are in the lingering effects of combat stress and behavioral health upon return home from combat and prolonged operations. Although current reserve policy is a step in the right direction by targeting prevention, it does not address the key component which is the gap in the cultural environments between the reserve component and active component.

Endnotes

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